

**phn**  
DARLING DOWNS  
AND WEST MORETON

An Australian Government Initiative

# Quality Improvement Toolkit for General Practice PIP QI - 10 Measures Module



## Introduction

### THE QUALITY IMPROVEMENT TOOLKIT

This Quality Improvement (QI) Toolkit is made up of modules that are designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients. The Toolkit will help your practice complete QI activities using the Model for Improvement.

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the Model for Improvement.

The Model for Improvement uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- it is a simple approach that anyone can apply
- it reduces risk by starting small
- it can be used to help plan, develop and implement change that is highly effective.

The Model for Improvement helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is an Influenza example using the Model for Improvement and a blank template for you to complete at the end of this module.

If you would like additional support in relation to QI in your practice please contact Darling Downs and West Moreton PHN on [practicesupport@ddwmpnh.com.au](mailto:practicesupport@ddwmpnh.com.au)

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Darling Downs and West Moreton PHN if you have any feedback regarding the content of this document.

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# PRACTICE INCENTIVE PROGRAM (PIP) QI 10 MEASURES

## QUALITY IMPROVEMENT

Quality improvement is foundational to contemporary high performing primary care. It includes team-based approaches, peer review, reflective practice, best practice, and data analysis. It can improve uptake of evidence-based practices for better patient outcomes, better professional development, and better system performance.

## PIP QI INCENTIVE

The PIP QI Incentive (PIP QI) is a payment to general practices for activities that support continuous quality improvement in patient outcomes and the delivery of best practice care. General practices enrolled in PIPQI commit to implementing continuous quality improvement activities that support them in their role of managing their patient's health. They also commit to providing nationally consistent, general practice data, initially in ten key Improvement Measures that contribute to local, regional and national health outcomes. Improvement Measures allow the practice to understand which patients may benefit from preventative treatments or may need recall to ensure effective management of a specified chronic disease (e.g. Type 2 Diabetes). This can help delay progression of the condition, improve quality of life, increase life expectancy, and decrease the need for high cost interventions.

## PIP QI IMPROVEMENT MEASURES

The collection of the de-identified Improvement Measures that form the PIP Eligible Data Set are part of a system of quality improvement that includes reflective practice, a common data baseline, and data analysis. The Improvement Measures are not designed to assess individual general practice or general practitioner performance. They do support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need. The first tranche of Improvement Measures are:

- QIM 1.** Proportion of patients with diabetes with a current HbA1c result
- QIM 2.** Proportion of patients with a smoking status
- QIM 3.** Proportion of patients with a weight classification
- QIM 4.** Proportion of patients aged 65 and over who were immunised against influenza
- QIM 5.** Proportion of patients with diabetes who were immunised against influenza
- QIM 6.** Proportion of patients with COPD who were immunised against influenza
- QIM 7.** Proportion of patients with an alcohol consumption status
- QIM 8.** Proportion of patients with the necessary risk factors assessed to enable CVD assessment
- QIM 9.** Proportion of female patients with an up-to-date cervical screening
- QIM 10.** Proportion of patients with diabetes with a blood pressure result

## HOW TO CHECK YOUR PRACTICE PATIENT DATA?

It's important from a practice perspective to review your data and systems to identify if you are meeting targets. There are 2 options you can choose from to obtain this information:

**Option 1:** Data Collection from CAT4 – please refer to the CAT4 recipes on

<http://help.pencs.com.au/display/CR/CAT+RECIPES>

**Option 2:** Refer to your GP Data PIP QI Reports in the PHN Exchange as provided by the Darling Downs and West Moreton PHN

**Log into the PHN Exchange** to view your practice's GP Data Reports.

<https://www.phnexchange.com.au/home.php?phn=304>

## Activity 1 Data Collection from CAT4

### Activity 1 – Data collection from CAT4

Complete the below table by collecting data from your CAT4 Data Extraction Tool.



Note - Instructions on how to extract the data is available from the PenCS website:  
<http://help.pencs.com.au/display/CR/CAT+RECIPES>

***The aim is to collect data to determine the number of patients in your practice according to the Improvement Measures as per the PIP QI guidelines.***

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

|             | Description   | Total Number | Current % of patient's achieving the measures | Goal/target to improve |
|-------------|---|--------------|---|------------------------|
| <b>1.1</b>  | Number of active patients with diabetes.<br><b>Note:</b> Don't include gestational diabetes in this total.  |              |   |                        |
| <b>1.1a</b> | <b>QIM 1.</b> HbA1c status for active patients with diabetes recorded in the last 12 months. <a href="#">Pen CS Instructions</a><br><br>Note: Select 'Diabetes – YES' when selecting filters.                                       |              |   |                        |
| <b>1.1b</b> | <b>QIM 5.</b> Number of active patients with diabetes who were immunised against influenza in the previous 15 months. <a href="#">Pen CS Instructions</a>   |              |   |                        |
| <b>1.1c</b> | <b>QIM 10.</b> Number of active patients who have diabetes and who have had a blood pressure measurement result recorded in the previous 6 months. <a href="#">Pen CS Instructions</a>  |              |   |                        |
| <b>1.2</b>  | Number of active patients aged 15 years and over.   |              |   |                        |
| <b>1.2a</b> | <b>QIM 2.</b> Number of active patients aged 15 years and over whose smoking status has been recorded I the last 12 months as one of the following: current smoker; ex-smoker; or never smoked. <a href="#">Pen CS Instructions</a> |              |   |                        |
| <b>1.2b</b> | <b>QIM 3.</b> Number of active aged 15 years and over and who have had their Body Mass Index (BMI) classified as obese, overweight, healthy, or underweight within the previous 12 months. <a href="#">Pen CS Instructions</a>      |              |   |                        |

|      | Description   | Total Number | Current % of patient's achieving the measures | Goal/target to improve |
|------|---|--------------|---|------------------------|
| 1.2c | <b>QIM 6.</b> Number of active patients who are aged 15 years and over, are recorded as having chronic obstructive pulmonary disease (COPD) and were immunised against influenza in the previous 15 months. <a href="#">Pen CS Instructions</a>   |              |   |                        |
| 1.2d | <b>QIM 7.</b> Number of active patients who are aged 15 years and over who have had their alcohol consumption status recorded. <a href="#">Pen CS Instructions</a>  |              |   |                        |
| 1.3  | Number of active patients aged 65 years and over.   |              |   |                        |
| 1.3a | <b>QIM 4.</b> Number of active patients aged 65 years and over who were immunised against influenza in the previous 15 months. <a href="#">Pen CS Instructions</a>  |              |   |                        |
| 1.4  | Number of active patients aged 45 to 74 years.  |              |   |                        |
| 1.4a | <b>QIM 8.</b> Number of active patients aged 45 to 74 years with information available to calculate their absolute CVD risk. <a href="#">Pen CS Instructions</a><br><br><b>Note:</b> This includes tobacco smoking, diabetes, systolic blood pressure, total cholesterol and HDL cholesterol levels, age and sex  |              |   |                        |
| 1.5  | Number of active female patients aged 25 to 74 years.   |              |   |                        |
| 1.5a | <b>QIM 9.</b> Number of active female patients aged 25 to 74 years, who have not had a hysterectomy and who have had a cervical screening [either Papanicolaou smear (Pap test) within the previous 2 years, or human papillomavirus (HPV) test] within the previous 5 years. <a href="#">Pen CS Instructions</a> |              |   |                        |

**Please note:** to work out percentage divide the number of patients with the data measures completed by the total age population and then multiply by 100. (For e.g. If your practice has 334 patients with diabetes and only 277 have had a HbA1c completed in the past 12 months, 277 divided by 334 multiply by 100).

Reflection comments as a result of completing Activity 1:

|                       |              |
|-----------------------|--------------|
|                       |              |
|                       |              |
|                       |              |
|                       |              |
| <b>Practice name:</b> | <b>Date:</b> |
| <b>Team member:</b>   |              |

## Activity 2. PIP QI Practice Improvement Plan

### Activity 2.1 – Checklist for reflection PIP QI Improvement Measures



Complete the checklist below to review your practice's data to meet the PIP QI Improvement Measures.

| Activity 2.1 – Reviewing PIP QI Improvement Measures  |   |  |
|---|---|--|
|   | Status  | Action to be taken   |
| After reviewing your PIP QI Improvement Measures are there any unexpected results?                              | <input type="checkbox"/> Yes, see action to be taken<br><input type="checkbox"/> No, continue with activity                       | <input type="checkbox"/> What observations have you made?<br><input type="checkbox"/> What action will you take?<br><input type="checkbox"/> How will you use this information to improve the numbers? |
| Do you know the contact details for the Practice Incentive Payment Program for any PIP QI related questions?    | <input type="checkbox"/> Yes, continue with activity<br><input type="checkbox"/> No, see actions to be taken                      | <input type="checkbox"/> PIP QI Email: <b>pip@servicesaustralia.gov.au</b><br><input type="checkbox"/> PIP QI Enquiry Line - 1800 222 032  |
| Are there any changes with the PIP QI improvement measures you would like to implement over the next 12 months? | <input type="checkbox"/> Yes, set goals and outline in actions to be taken<br><input type="checkbox"/> No, continue with activity | Refer to the Model for Improvement to help set goals at the end of this module.  |

Reflection comments as a result of completing Activity 2.1:

|                       |              |
|-----------------------|--------------|
|                       |              |
|                       |              |
|                       |              |
|                       |              |
| <b>Practice name:</b> | <b>Date:</b> |
| <b>Team member:</b>   |              |



## Activity 2.2 – Example PDSA of PIP QI Improvement Measures



Select from the below table some suggested goals related to the PIP QI measures you may wish to achieve within your practice.

If you identified in activity 2.1 that you would like to implement some changes within your practice to improve your practices results on the 10 PIP QI Improvement Measures, then it is recommended that you use the **Model for Improvement** worksheet at the end of this document to guide you to make successful changes.

The Model for Improvement provides a framework for developing, testing and implementing changes in a way that will lead to improvement.

| Goal  | How you may achieve the goal   |
|---|--|
| Ensure all active patients with diabetes are coded correctly and have a HbA1c recorded in the past 12 months  | <b>Refer to Pen CS</b> <a href="#">identifying patients with diabetes with no HBA1C recorded in the past 12 months</a>   |
| Ensure 90% of active patients aged 15 years and older have smoking status – current smoker, ex-smoker or never smoked   | <b>Refer to Pen CS</b> <a href="#">identifying patients with no allergy or smoking status recorded</a>   |
| Ensure 75% of active patients aged 15 years and older have BMI classified as obese, overweight, healthy or underweight within the previous 12 months  | <b>Refer to Pen CS</b> <a href="#">adding, height, weight and waist measurements to patients records</a>   |
| Increase the number of flu injections given to active patients aged 65 years and over the past 15 months by 10%   | <b>Refer to Pen CS</b> <a href="#">identify the number of active patients 65 years and over who have not received a flu injection in the past 15 months</a>  |
| Increase the number of flu injections given to diabetes patient over the past 15 months by 10%  | <b>Refer to Pen CS</b> <a href="#">identify the number of diabetes patients who have not received a flu injection in the past 15 months</a>  |
| Increase the number of flu injections given to patients with COPD over the past 15 months by 5%   | <b>Refer to Pen CS</b> <a href="#">identify the number of COPD patients who have not received a flu injection in the past 15 months</a>  |
| Ensure 90% of active patients aged 15 years and older have their alcohol status recorded  | <b>Refer to CAT4</b> <a href="#">identify the list of patients who do not have their alcohol status recorded</a>   |
| Increase by 10% the number of patients aged 45 to 74 years with the following:<br>Smoking status<br>Blood pressure<br>Total cholesterol and HDL levels<br>(you may wish to do this as part of a <a href="#">healthy heart check</a> MBS item 699) | <b>Refer to CAT4</b><br><a href="#">identify patients with no allergy or smoking status recorded</a><br><a href="#">identify patients with no bp recorded</a><br><a href="#">identify patients with no cholesterol and hdl levels recorded</a> |
| INCREASE THE CERVICAL SCREENING OF THE NUMBER OF ELIGIBLE FEMALE PATIENTS AGED 25 TO 74 YEARS BY 10%  | <b>Refer to CAT4</b> <a href="#">identify eligible for cervical screening</a>  |
| Ensure that 90% of active diabetes patients have their blood pressure recorded  | <b>Refer to CAT4</b> <a href="#">patients with CVD with no BP recorded</a> – Please note: you will be required to select 'Diabetes -YES' instead of CVD  |

### Other ideas:

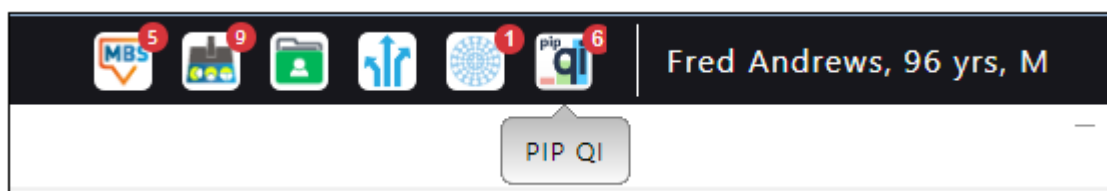
- Ask the practice nurse to opportunistically see patients prior to their GP appointment to obtain height, weight, waist measurements, BP, smoking and alcohol status; OR
- Ask patients to complete a summarised new patient form with their height, weight, waist measurements, BP, smoking and alcohol status and also check their address, contact details, NOK and emergency contact
- Develop a reminder list e.g. proactively contact patients with COPD who have not yet had their flu injection
- Ensure Topbar is installed on every workstation and fully operational.
- **Each** active patient health record has the patient's current health summary that includes, where relevant:
  - adverse drug reactions
  - current medicines list
  - current health problems
  - past health history
  - immunisations
  - family history
  - health risk factors (eg smoking, nutrition, alcohol, physical activity)
  - social history, including cultural background.
- The practice codes allergies and adverse reaction in line with digital health and general practice standard. This important information becomes available to others in the patient's care team:
  - a. clearly visible within the medical record
  - b. easily extracted onto referral letters, care plans, admission reports and My Health Record summaries.
- Clinical staff upload and view Shared Health Summaries or Event Summaries to My Health Record to ensure accurate information is available to all providers involved in the team care of our patients.

### USING TOPBAR FOR PIP QI IMPROVEMENT MEASURES

Topbar prompts administrative and clinical staff to opportunistically capture missing demographic or clinical information at the point of care. It can play a significant role in improving general practice data quality, chronic disease management and eHealth. Topbar is available for practices using Best Practice, MD3 or ZedMed software.

Topbar has five main applications that can be tailored to meet the practice needs.

- **The Waiting Room App** provides staff with a quick view of patients who are currently in the waiting room and missing demographic or clinical data.
- **The Cleansing App** provides the clinician with a quick view of the patients' record and highlights missing demographic and clinical information.
- **The MBS App** shows recommended actions and claim status relating to the Medicare Benefits Schedule (MBS).
- **The Patient Health Summary App** displays information from the patients' medical record and displays it in chronological order.
- **The PIP QI App** instantly presents the information about the ten improvement measures for the patient currently open in your clinical system. Notifications are displayed as a number in the red circle and the app is located on the right-hand side of your Topbar.



Click here to access the [Topbar Apps](#)

## **ADDITIONAL RESOURCES**

[RACGP General Practice Management Toolkit – Managing Quality](#)

[PIP QI Guidelines](#)

[PIP Improvement Measures](#)

[PIP Eligible Data Set Data Governance Framework](#)

[PIP QI Who do I ask](#)

[PIP QI FAQs](#)

[Change Program Toolkit](#)

After completing any of the workbook activities, you may identify areas for improvement in the management of patients. Follow these steps to conduct a QI Activity using The Model for Improvement and PDSA

## THE MODEL FOR IMPROVEMENT AND PDSA

The model consists of two parts of equal importance.

**Step 1:** The '**thinking**' part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

**Step 2:** The '**doing**' part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. This includes:

- Helping you test the ideas
- Helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

## THE PLAN-DO-STUDY-ACT (PDSA) CYCLE

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change—you develop a plan to test the change (Plan), carry out the test (Do), observe, analyse, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet (at the end of this document) for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

**Plan:** **Plan the test, including a plan for collecting data.**

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.

**Do:** **Run the test on a small scale.**

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyse the data.

**Study:** **Analyse the results and compare them to your predictions.**

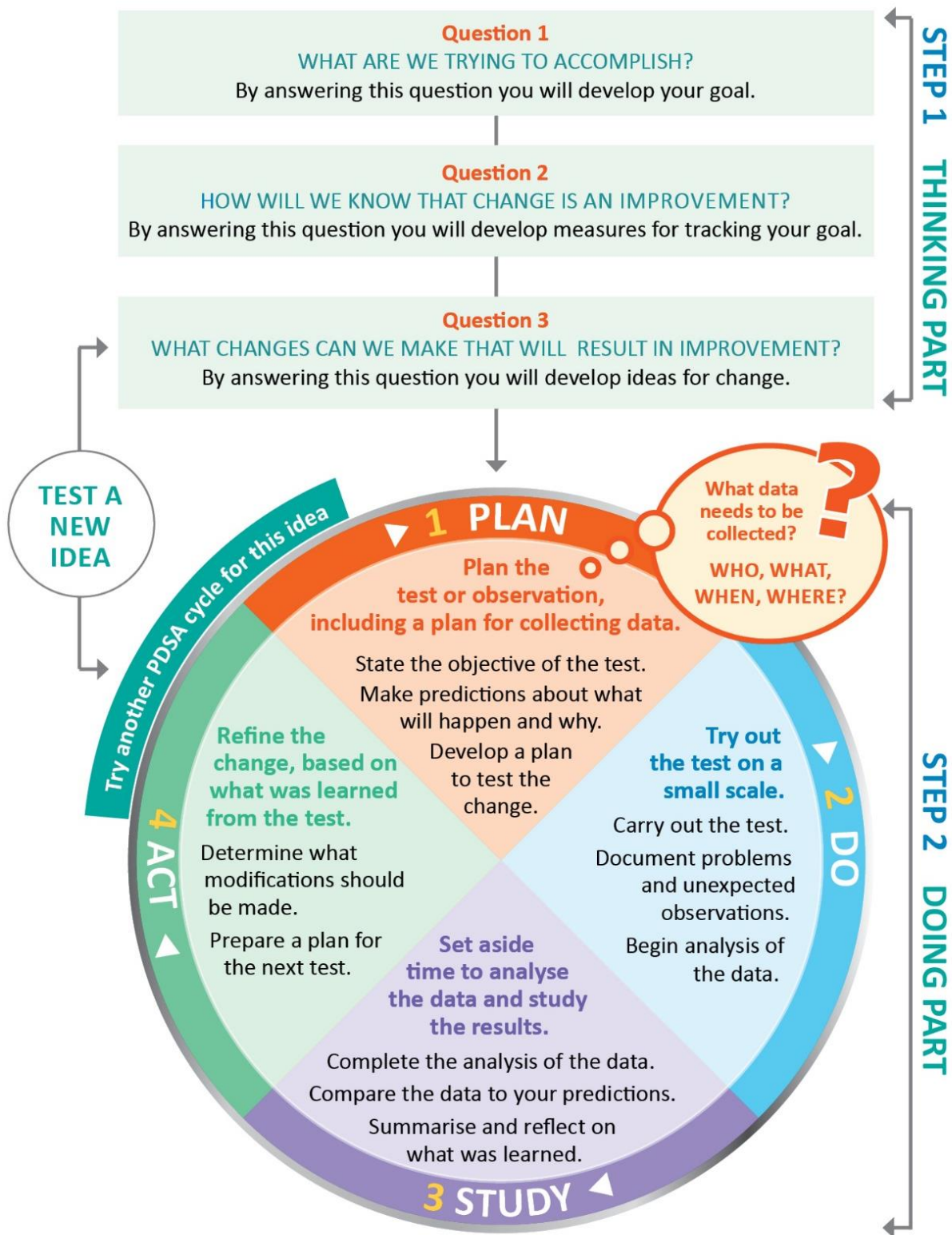
- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

**Act:** **Based on what you learned from the test, make a plan for your next step.**

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

To find out more about QI, please contact your Darling Downs and West Moreton PHN Primary Care Liaison Officer (PCLO) directly or email [practicesupport@ddwmpnh.com.au](mailto:practicesupport@ddwmpnh.com.au)

# The model for improvement diagram




Source: <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

## THE MODEL FOR IMPROVEMENT AND PDSA WORKSHEET EXAMPLE

### Step 1: The Thinking Part

#### The 3 Fundamental Questions

|   |              |
|---|--------------|
| <b>Practice name:</b>   | <b>Date:</b> |
| <b>Team member:</b>   |              |
| <b>Q1. What are we trying to accomplish? (Goal)</b>   |              |
| <i>By answering this question, you will develop your goal for improvement</i>   |              |
| <ul style="list-style-type: none"> <li>• Our goal is to:</li> <li>• Ensure patients who have a diagnosis of COPD receive an influenza vaccine.</li> <li>• <i>This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.</i></li> <li>• <i>So, for this example, a better goal statement would be:</i></li> <li>• Our S.M.A.R.T. goal is to:<br/>Increase the proportion of our active patients with COPD who have an influenza vaccine by 20% by 31 July.</li> </ul>  |              |
| <b>Q2. How will you know that a change is an improvement? (Measure)</b>   |              |
| <i>By answering this question, you will develop MEASURES to track the achievement of your goal. E.g. Track baseline measurement and compare results at the end of the improvement.</i>  |              |
| <p>We will measure the percentage of active patients with COPD who have had a flu vaccine. To do this we will:</p> <ul style="list-style-type: none"> <li>A) Identify the number of active patients with COPD</li> <li>B) Identify the number of active patients with COPD who have had a vaccine</li> </ul> <p>B divided by A x 100 produces the percentage of patients with COPD who have had a flu vaccine</p>   |              |

**Q3. What changes could we make that will lead to an improvement?**

**(List your IDEAS)**

*By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.  
You may wish to BRAINSTORM ideas with members of our Practice Team.*

Our ideas for change:

1. Using CAT4, identify active patients with COPD who have not had a flu vaccine this year
2. Identify patients from list exported from CAT4 and send SMS recall via hot docs
3. Check vaccine stock, reorder if available
4. Source and provide endorsed patient education resources on flu vaccination (in waiting rooms, etc)
5. Run an awareness campaign for COPD

The team selects one idea to begin testing with a PDSA cycle

**Note:** Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide

**Source:** Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

## THE MODEL FOR IMPROVEMENT AND PDSA WORKSHEET EXAMPLE

### Step 2: The Doing Part

#### Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1  
You will use this sheet to test an idea.

| PLAN  | Describe the brainstorm idea you are planning to work on. (Idea)                                      |
|---|---|
| <i>Plan the test, including a plan for collecting data</i>  | <i>What exactly will you do? include what, who, when, where, predictions and data to be collected</i> |
| <p><b>Idea:</b> Identify active patients with COPD who have not had a flu vaccine recorded this year.</p> <p><b>What:</b> Mary will conduct a search on CAT4 and identify active patients with COPD who have not had a flu vaccine recorded this year.</p> <p><b>Who:</b> Receptionist (Mary)</p> <p><b>When:</b> Begin 20 May</p> <p><b>Where:</b> at the practice in Dr Bills room</p> <p><b>Prediction:</b> 60% of the active COPD patient population will have had their flu vaccine recorded this year.</p> <p><b>Data to be collected:</b> Number of active COPD patients and number of active COPD patients who have not had a flu vaccine recorded this year.</p> |   |
| DO  | Who is going to do what? (Action)   |
| <i>Run the test on a small scale</i>  | <i>How will you measure the outcome of your change?</i>   |
| <p>Completed 20 May – the receptionist contacted Brisbane South PHN for support with the PenCS CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches.</p>   |   |



| STUDY   | Does the data show a change? <span style="float: right;">(Reflection)</span>   |
|---|--|
| <i>Analyse the results and compare them to your predictions</i>   | <i>Was the plan executed successfully?<br/>Did you encounter any problems or difficulty?</i>   |
| A total of 40 active patients (50%) with COPD have had their influenza vaccine status recorded this year = 10% lower than predicted.  |  |
| ACT   | Do you need to make changes to your original plan?<br>OR Did everything go well? <span style="float: right;">(What next)</span>  |
| <i>Based on what you learned from the test, plan for your next step</i>   | <i>If this idea was successful you may like to implement this change on a larger scale or try something new<br/>If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance</i> |
| <ol style="list-style-type: none"> <li>1. Identify patients from list exported from CAT4 and send SMS recall</li> <li>2. Create a PenCS Topbar prompt to ensure all patients with COPD have a flu vaccine offered and result recorded at their next appointment. Review this by 31 July (in two months' time) to determine if there has been an increase in the number of patients with flu vaccine status recorded.</li> <li>3. Ensure the clinical team know where to record the vaccine status in the medical software.</li> <li>4. Remind the whole team that this is an area of focus for the practice.</li> </ol> |  |

**Repeat Step 2 for other ideas – What idea will you test next?**



**Q3. What changes could we make that will lead to an improvement?**

**(List your IDEAS)**

*By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.  
You may wish to BRAINSTORM ideas with members of our Practice Team.*

**Idea:**

**Idea:**

**Idea:**

**Idea:**

**Note:** Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.

**Source:** Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, *The Improvement Guide*, Jossey-Bass, San Francisco, USA.

## THE MODEL FOR IMPROVEMENT AND PDSA WORKSHEET TEMPLATE

### Step 2: The Doing Part

#### Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1  
You will use this sheet to test an idea.

| PLAN   | Describe the brainstorm idea you are planning to work on. (Idea)                                      |
|--|---|
| <i>Plan the test, including a plan for collecting data</i> | <i>What exactly will you do? Include what, who, when, where, predictions and data to be collected</i> |
|  |   |
| DO   | Who is going to do what? (Action)   |
| <i>Run the test on a small scale</i>                       | <i>How will you measure the outcome of your change?</i>   |
|  |   |

| STUDY  | Does the data show a change? <span style="float: right;">(Reflection)</span>  |
|--|---|
| <p><i>Analyse the results and compare them to your predictions</i></p>         | <p><i>Was the plan executed successfully?<br/>Did you encounter any problems or difficulty?</i></p>   |
|  |   |
| ACT  | Do you need to make changes to your original plan?<br>OR Did everything go well? <span style="float: right;">(What next)</span>   |
| <p><i>Based on what you learned from the test, plan for your next step</i></p> | <p><i>If this idea was successful you may like to implement this change on a larger scale or try something new.<br/>If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.</i></p> |
|  |   |

**Repeat Step 2 for other ideas - What idea will you test next?**

# Digital health tools that can assist your practice with Quality Improvement

## HEALTHPATHWAYS

HealthPathways is a local online portal assisting GPs and other health professionals with information about clinical assessment and management, and clear referral pathways into local services. HealthPathways is being actively promoted as the principal tool for use during consultations.

The pathways are written by experienced, local GPs and are reviewed by qualified experts (e.g. medical specialists). It is anticipated HealthPathways will become the main resource utilised by GPs to inform treatment and referral decisions.

DDWMPHN supports two HealthPathways portals – Darling Downs and West Moreton:

To access the portals, visit <https://www.ddwmhealthpathways.com.au>

## SMART REFERRALS

The Smart Referrals programs supports clinical and business change through the streamlined creation and management of referrals to Queensland specialist outpatient services. Smart Referrals allows those involved in patient care to better manage the patient journey, improve patient safety and reduce specialist outpatient wait times.

Program components include GP Smart Referrals, allowing GPs to create and submit electronic referrals from existing practice software.

- Learn more about Smart Referrals from the QLD Health site [HERE](#)
- View Smart Referral resources and PDF Guides to installation and set up [HERE](#)

## THE QUEENSLAND HEALTH VIEWER – THE VIEWER

The Health Provider Portal (HPP) service provides a summary patient healthcare details to registered and authenticated health practitioners. All information on display is provided via secure tunnel access to Queensland Health's read-only clinical application, The Viewer. This read-only online access will allow GPs to view public hospital information including appointment records, radiology and laboratory results, treatment and discharge summaries, and demographic and medication details.

- Learn all about The Viewer and FAQs [HERE](#)
- Already registered? Access The Viewer [HERE](#)
- Email the team: [connectingqld@health.qld.gov.au](mailto:connectingqld@health.qld.gov.au)

## MY HEALTH RECORD

It is important to upload a [Shared Health Summary](#) (SHS) to the [My Health Record](#) of a patient with a chronic or complex condition to ensure continuity of care throughout their healthcare journey and ensure practice [eHealth Practice Incentive Payment \(ePIP\)](#) eligibility criteria are met.

- See cheat sheets on how to upload information to the My Health Record system [HERE](#)
- See a 1 min video on how to upload a SHS in Best Practice software [HERE](#)
- See a 1 min video on how to upload a SHS in Medical Director software [HERE](#)

- Access refresher training and eLearning modules [HERE](#)
- Read about eHealth on the RACGP website [HERE](#)
- Don't have access to the My Health Record system or claim the [ePIP?](#)

Start registration process [HERE](#).

## **ELECTRONIC PRESCRIPTIONS**

Electronic prescriptions will improve medicines safety and provide new options and convenience for patients and their medicine supply, allowing prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription.

Electronic prescriptions form part of the broader digital health and medicines safety framework. They enable the prescribing, dispensing and claiming of medicines, without the need for a paper prescription. Existing prescribing and dispensing processes will not change. Patients can still choose which pharmacy they attend to fill their prescription and can choose an electronic prescription as an alternative to a paper prescription. Paper prescriptions will still exist.

Learn more about Electronic Prescriptions from the Australian Digital Health Agency site [HERE](#).

## ACKNOWLEDGEMENTS

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Should the document require updating or if any errors are identified please contact the Darling Downs and West Moreton PHN's Data and Analytics team on: [practicesupport@ddwmphn.com.au](mailto:practicesupport@ddwmphn.com.au)

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